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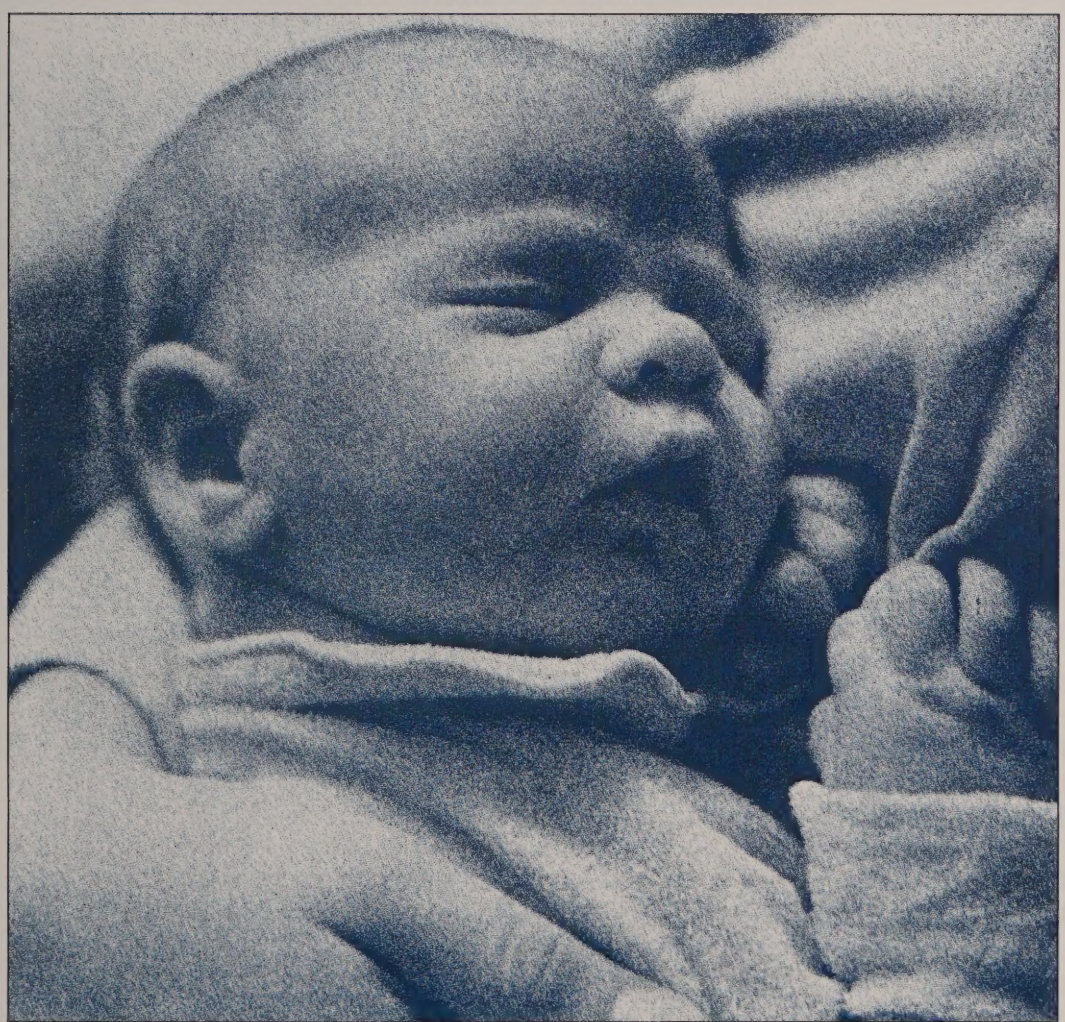

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THE
Hampden Hippocrat

JANUARY—FEBRUARY 1992

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The official bulletin for The Hampden District of the Massachusetts Medical Society. Founded in 1942 by Edward P. Bagg, Jr., M.D. and William A. R. Chapin, M.D.

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From the Editors

Perhaps the biggest gulf in medicine is between those of us who take care of "real people" and our colleagues, the pediatricians. As the years go by, we draw further apart professionally, finding that we speak different and almost mutually incomprehensible dialects. Thus its good once in a while to find out what is going on around us. We are fortunate in that we have a vibrant pediatric community in Western Massachusetts. In addition to the specialty programs described here, we hear from a large general pediatric practice. Western Massachusetts has a nationally prominent residency program in Medicine-Pediatrics.

Maybe its a false perception, but in our medical community, only the pediatricians seem to have more or less solved the town/gown/HMO/private practice antagonisms. Maybe they know something the rest of us don't. ■

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Hampden Committee Activities

Alfred G. Garcia, M.D, brings us up to date on recent activities of our society.

The Executive Committe reviewed multiple programs in the previous month. Included was a report of the House Calls Program. Over 1,000 telephone calls were received on the evening of October 20th. The program was enthusiastically received by the public. At 10:00 p.m., the fourteen Cardiologists were still answering phone calls. Our benefactor, Merck, Sharp & Dohme, expressed their desire to sponsor another program along the same lines. The AMA has grant monies that they are offering to district societies in support of local programs. A video tape of the House Calls Program will be sent to the AMA with a grant application.

The Auxiliary Party for the Jefferson Avenue Women's Shelter was held on November 15th at the home of Dr. & Mrs. Peter Demos. The party was well attended and approximately $2,000.00 was collected. This amount will be matched by the Hampden District Medical Society Auxiliary.

The Medical Ethics Seminar that was held on October 23rd was attended by 128 persons and their responses on evaluations were very positive. The topic was, "Heightened Awareness of HIV Related Problems".

On October 30th, a Mass. PRO meeting was held with Doctors McDermott, McCarthy and Richardson discussing the problems encountered by physicians from Holyoke, Westfield and Springfield. Dr. Richardson did say that compared to other PRO's around the country, ours was very benign.

Dr. Weiss was chosen to be Chairperson for the next Doctor For A Day Program which will begin shortly. This will bring together physicians and area legislators.

Dr. Francis Murray will take over the Chair of the Medico-Legal Committee, replacing Dr. Lester Frank. The Medico-Legal Committee will meet on January 9th, along with members of the Bar Association. This Committee hopes to meet and discuss the problems between physicians and lawyers in the community.

The speaker for the HDMS Annual Meeting will be Mr. John Edwin Mroz, President of the Institute for East-West Security Studies.

The Public Health Committee met on Oct. 8th. The Committee reviewed the resolution to be presented to the Mass. Medical Society Council Meeting by the MMS Public Health Committee. The resolution will adopt an HIV Infection and AIDS Policy.

Also discussed was the plan to encourage Superintendent Negroni of the Springfield School System in supporting the prevention of the transmission of Sexually Transmitted Diseases in the face of rising AIDS figures.

A representative of the American Cancer Society outlined a program entitled, "Massachusetts Coalition For A Healthy Future". This program would get a petition on the 1992 ballot which would increase the state's cigarette tax by 25 cents.

The Medico-Religious Committee suggested that the topic for the next year's seminar would be, "Health Care Proxy—One Year Later". There was also a discussion abou the possiblities for members of the panel. ■

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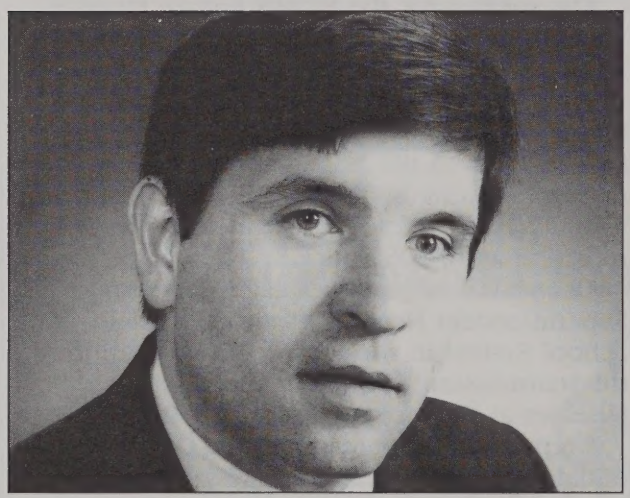
National Health Insurance —Again

Those "code words" and phrases are back with a vengeance. Since Wofford thrashed Thronburgh in the Pennsylvania run-off election for a U.S. Senate seat, many of those supposedly in the know have interpreted Wofford's victory as a mandate for some kind of national health insurance policy. While I disagree with this evaluation-in light of the fact that his proposal had no specifics, It was simply a win for someone who seemed to be offering something for nothing—it clearly has stimulated a great deal of needed debate.



Mark J. Mullan, M.D., President

Anyone in the medical profession with better than 20/400 vision should be able to see that some change is needed. Too many people are either uninsured, underinsured or simply falling through the cracks in the system. But we should be suspicious of anyone who thinks they have the answer because nobody has it. The terms these supposed soothsayers use discussing their ideas are many and varied. Five of them stick out in my mind: National Health Insurance (based on The Canadian System); Health Access America; Administrative Costs; Access; Standard Benefits.

Most who speak of NHI wallow in glittering generalities, as did Wofford. They often don't have specific plans or ideas and point to the North and say that is how things should be done. Numerous basic differences between our countries' medical systems are never addressed.

Health Access America is the AMA plan for reform. Included in this package are employer-mandated coverage, Medicaid and Medicare changes, creating state level risk pools, long term coverage and tort reform. It invigorates me to see the AMA grass roots campaign to put forward their well-detailed plan, but on thorough examination most people can see a number of flaws which would certainly prevent adoption of this proposal as a whole.

Many of the over thirty health care reform bills filed in Congress speak to the difference in Administrative Costs between the U.S. and Canadian systems. No one would doubt that these costs are greater here but it is totally unrealistic to believe, as many do, that simply reducing these cost to Canadian level will fund much of a new system.

The famous New England Journal article of Woolhandler and Himmelstein suffers from several deficiencies and presents some unsubstantiated assumptions in the absence of real data.

Access is probably the greatest buzz word of them all. How can anyone not agree that it is a grave problem? But few of the experts address the difficulty in access in a system with rapidly decreasing numbers in primary care disciplines, those physicians who purportedly will be the initial contact for the majority of people. And how is the government going to ensure that

rural and inner-city residents will have any physicians at all?

Everyone has different ideas about the Standard Benefits which would be covered in any of these reform plans. In a society in which demands and espectations are endless it would be difficult for any elected official to leave any benefit out of a package.

The Oregon Medicaid proposal, where a large number of benefits are rank ordered in terms of importance and funding cut off for those treatments below a budgeted level, has been battered by activists of all races, colors and medical creeds who believe that in this society all available means of therapy should be given to everyone.

You will note though that there are several key works and phrases missing in the debate. Important ones too. Like increased costs, higher taxes, rationing and increased demands. Giving a VISA Health America Gold Card will definitely result in greatly increased demands and costs in a society which is aging and hungry for any new technology with any chance to extend life. And though most polls show that over 70% of the population want some version of NHI, the same polls show that almost no one wants higher taxes to pay for it.

I am not one of those who pretends to have the answer. But unlike Boston Globe business columnist Dave Warsh, who wrote that physicians behind the Harvard Community Health Plan mutiny "scarcely knew what they were doing" at the same time intimating no practicing physician ever had any idea about health care, I strongly believe that we do understand better than anyone. We have to emphasize to our patients and elected officials that any reform plan must be discussed from the bottom line up—who is covered for what services and how we are going to pay for it. Any attempt to pick a general philosophy first and then discuss the details will quickly produce fiscal failure and health care disaster.

I have a recurring nightmare which dates back to pre-Presidential primary days when Michael Dukakis was proudly presenting his poorly designed Universal Health Care plan to the salivating liberal Massachusetts media, doting on his every word. The plan, rushed through in a hurried campaign, wasn't well understood by the Governor but that didn't matter. It was a plan and he had to show it off to the press. Barely noticed at the time was his answer to a vital question, "How much will this plan cost?". He smiled, said he didn't know and turned to someone for the answer.

Unfortunately this scene is all too familiar. Ask Senator Wofford or any of the Democratic Presidential candidates. ■

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Exercise Stress Testing In Children

Thomas W. Rowland, M.D., is the Chief of Pediatric Cardiology at Baystate Medical Center, and shares his insights into the role of stress testing in the care of children.

The goals of exercise stress testing are straightforward ones: place the body's systems under physical stress, assess functional limits, and uncover abnormalities not apparent at rest. It's a common sense approach, since most humans do not typically spend much time lying supine on an examination table. Yet physicians are taught to assess wellness and disease in just this static state, with the human machine on "idle." Exercise testing puts that machine on the "test track," evaluating its performance characteristics in conditions that more closely mimic those activities of daily living.

The value of stress testing in children is becoming increasingly apparant.

The greatest use of exercise testing has involved the evaluation of adults with cardiovascular disorders, particularly coronary artery disease. Attention is directed principally to electrocardiographic expressions of dysrhythmias and myocardial ischemia, important considerations in the evaluation of coronary insufficiency. Exercise testing in children and adolescents, who do not have atherosclerotic coronary artery disease, is an outgrowth of this larger experience in adults, and the value of stress testing of youngsters has become increasingly apparent.

It is clear, however, that a number of important considerations call for different testing approaches when evaluating children. The indications for exercise testing of pediatric patients are broader than in adults, and discrepencies of age, size, and fitness levels are much larger. Within the pediatric age group are encompassed subjects ranging from elite endurance athletes to those who have difficulty negotiating a moving treadmill belt or pedalling a cycle with a regular rhythm. Consider, for example, the different approaches necessary to evaluate ventricular rate response in a 4-year old with complete heart block and a 15-year old cross country runner who has complaints of increasing shortness of breath during competitive events.

Encouragement of children to provide a satisfactory exercise testing effort requires special sensitivity on the part of laboratory personnel, and equipment must be appropriate for younger ages. A maximal exercise response is important in most testing situations. That will not be difficult for the high school endurance athlete but will require considerable staff encouragement in the very young, unfit, or obese subject. Nevertheless, satisfactory maximal efforts can be induced in patients as young as 3-5 years.

The use of exercise testing to identify functional limits and detect disease states in children is rapidly expanding. Clearly the value of exercise testing extends beyond that of cardiovascular function; testing may play an important role in the evaluation of patients with a wide range of endocrine, musculoskeletal, metabolic, and pulmonary disorders. The following list provides examples of the more common indications for exercise testing in children.

1. Evaluation of cardiac and pulmonary functional capacity. By exercise duration, measurement of maximal oxygen uptake, or determination of cardiac output or ventilation, an estimate of cardiac or pulmonary reserve can be obtained to help guide management of patients with disease and/or assess results of surgery

2. Detection of myocardial ischemia. In pediatric patients, this includes assessment of severity of aortic stenosis, congenital coronary artery anomalies, and Kawasaki disease.

3. Evaluation of cardiac rhythm and rate. Exercise testing is useful in the detection and management of tachyarrhythmias (particularly ventricular), as well as assessing sinus node function and response to exercise in patients with complete heart block.

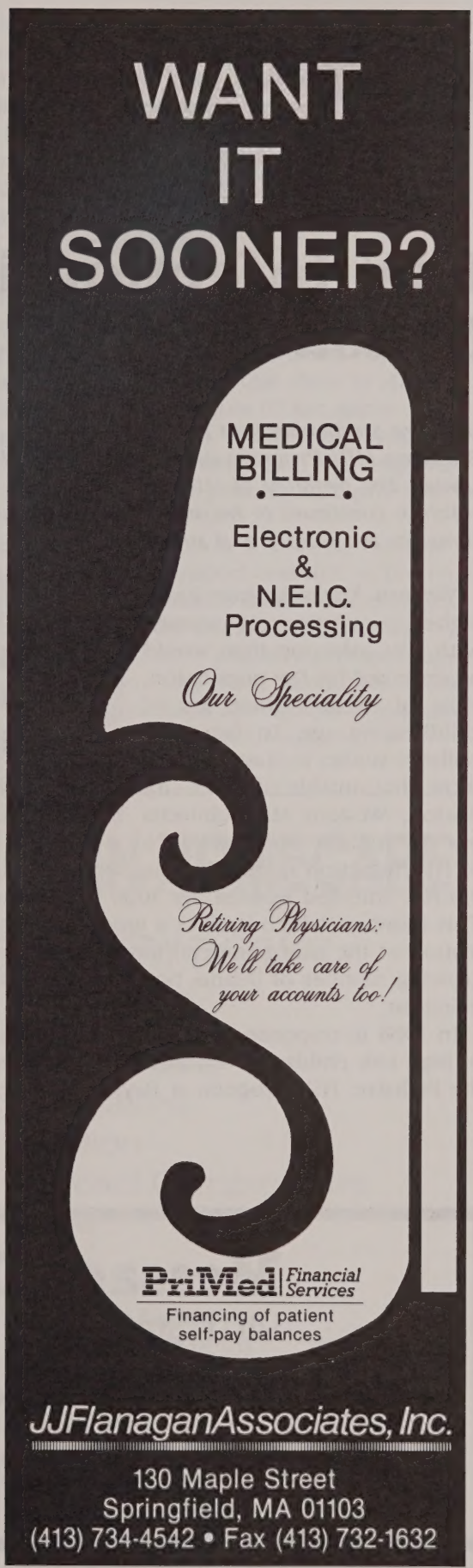
4. Determination of blood pressure response. Uncertainty surrounds the interpretation of exaggerated blood pressure levels with exercise. Excessive blood pressure rise during exercise in hypertensive patients, particularly competitive athletes, may indicate need for medical therapy.

5. Assessment of symptoms with exercise. Not uncommonly, physicians are confronted with a young patient who has complaints of chest pain, dizziness, or shortness of breath during exercise or sports participation. While these symptoms are not always indicative of significant disease, their evaluation with exercise testing is important.

6. Detection and management of exercise-induced asthma. In children, asthma induced by exercise is probably the most common cause of chest pain, breathlessness, or cough occurring during or immediately after physical activity. While formal exercise testing is not always necessary to make this diagnosis, treadmill or cycle testing to provoke and identify exercise-induced asthma can be useful in a) assessing effects of therapy, b) establising etiology in questionable cases, and c) separating exercise-induced asthma from competitive breathlessness in athletes.

7. Assessment of physical fitness. Exercise testing is useful in verifying the complaint of the patient with fatigue during physical activity. Physical performance rests upon the complex contributions of muscular, hematologic, metabolic, and cardiopulmonary, and psychologic factors. The natural course and responses to therapy in disease states in any of these determinants may be accurately reflected in exercise capacity.

Information gained from exercise testing can often be essential in guiding diagnosis and management of young patients with a wide variety of clinical problems. Newer applications (ie, blood pressure responses as predictors of hypertension risk, assessment of surgery in patients with muscular dystrophy) continue to be added to the more traditional indications for assessment of cardiac and pulmonary disease. The growing indications for exercise testing will provide increasing practical use of this procedure in the pediatric age group. ■



HIV Infection in Western Massachusetts

Barbara Stechenberg, M.D., directs the Pediatric HIV Program at Baystate Medical Center. The problem of HIV infection in children continues to increase, with repercussions for the family and society.

Western Massachusetts has a higher proportion of women with HIV infection than would be expected for the population. Most of these women are of childbearing age. In fact, surveillance studies in Massachusetts show that outside of inner-city Boston, Western Massachusetts has the highest seroprevalence of HIV infection in childbearing women with 3.6 HIV infected women per 1000 live births. This number (which itself is a gross underestimation of the true numbers) translates into a growing number of infants born at risk for HIV infection.

Two major problems in children with HIV infection include growth failure and developmental delay.

In 1988 in response to this increasing group of high risk children, we formally established the Pediatric HIV Program at Baystate Medical Center. Our program's center is the high risk infection clinic that is housed in the Pediatric Ambulatory Center. Through this clinic we have seen over 115 children at risk for HIV infection. We are now following 25 HIV infected children. As the source for tertiary care of these children we offer a multidisciplinary approach to their care including a social worker, nutritionist, psychologist and nurse clinicians as well as physicians on our team. We do not try to supplant the primary care provider but to provide diagnostic, therapeutic and educational support.

The diagnosis of HIV infection in the young child under 15 months of age can be problematic. Antibody testing alone (the way most adults are diagnosed) may only reflect maternally-acquired infection in utero. Only about 25-30% of babies born to HIV-infected mothers are truly infected. We offer specific testing for the virus including HIV culture, PCR (polymerase chain reaction) and P24 antigen detection, in order to

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make a diagnosis of true infection as soon as possible. We also start immunologic testing as early as one month of age; this is important since *Pneumocystis carinii* pneumonia is a particular problem in the first year of life. T-helper counts in children, particularly under 1 year of age, are normally very high; if counts in a child of an HIV-infected mother fall below a certain level (1500 cells/mm^3 if $\leq$ 12 months) PCP prophylaxis is started.

Why evaluate these children so early? The treatment of children with HIV infection is rapidly evolving. There are now two antiviral drugs approved for use in children, zidovudine (AZT) and dideoxyinosine (ddI). Since 1990 we have been linked as a subunit of the University of Massachusetts AIDS Clinical Trials Group, the network of NIH-sponsored trials. Through this network we offer our patients the opportunity to participate in the current research protocols. We also offer treatment that does not necessarily fall into the research categories.

Two major problems in children with HIV infection include growth failure and developmental delay. Our nutritionist meets with all our families. We have a strong link to our pediatric psychology and neurology division for early evaluation and treatment.

Our ties to the community services are paramount in the care of our patients. We have just been funded for participation in a state-wide pediatric AIDS demonstration project that links the four major pediatric HIV programs with towns with high HIV prevalence. With this funding we have started a monthly satellite clinic in Holyoke and offer special supports to our Holyoke patients.

Our philosophy recognizes the need for care to be child-centered as well as family-focused. For many of our symptomatic patients, the diagnosis of HIV in the child is the first recognition in the family that there is HIV disease. The mother learns of her status through our evaluation. We strongly support the concept of community care and emphasize the importance of the primary care provider in the child's continued care.

Pediatric HIV infection is a family disease. Our social service support and link to the community keep our families afloat. Our energies together are directed toward providing our children, their families and care providers up-to-date information, diagnostic techniques, therapy (antiviral, immunologic and against opportunistic diseases) as well as social support. ■

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New Developments in Pediatric Endocrinology

Paul Martha, M.D., a Pediatric endocrinologist in the Department of Pediatrics at Baystate Medical Center, updates us on the present and future of endocrine disorders in children.

Developments in the field of pediatric endocrinology over the past decade have largely paralleled the tremendous explosion in biotechnology research and development. The new tools thereby provided to physicians have brought major changes in both our diagnostic and therapeutic capabilities. In particular, significant advances have been achieved in our understanding and treatment of disorders of the neuroendocrine or, hypothalamic-pituitary axis during childhood.

The rapid growth in biotechnology... has an even greater impact on the field... through the provision of almost limitless quantities of highly purified hormone preparations for therapeutic use.

The greatest impact on our diagnostic capabilities has resulted from the widespread availability of synthetic human hypothalamic releasing factors. For example, the hypothalamic peptide gonadotropin-releasing hormone (GnRH), has been extremely helpful in evaluation of sexual precocity. In children with precocious sexual development, an early branch point in the diagnostic decision pathway involves determination of a central vs. peripheral etiology. In response to a rapid injection of GnRH, a normal prepubertal child demonstrates little to no gonadotropin release from the pituitary gland. This is also true in children with precocious sexual development of non-central origin (for instance, a gonadal or adrenal tumor). In contrast, a child with true central precocious puberty will respond with a brisk rise in both serum LH and FSH levels following injection of GnRH in a pattern similar to that of a normal adolescent. In fact, this "GnRH stimultation testing" has now become the "gold standard" test for diagnosis of precocious puberty. In a similar manner, the availability of other hypothalamic releasing factors including the growth hormone releasing hormone (GHRH), thyrotropin releasing hormone (TRH) and corticotropin releasing hormone (CRH), have also contributed significantly to our understanding of other disorders of the hypothalamic-pituitary axis.

The rapid growth in biotechnology, however, has had an even greater impact on the field of pediatric endocrinology through the provision of almost limitless quantities of highly purified hormone preparations for therapeutic use. For example, pure preparations of human insulin, produced through recombinant DNA techniques, are now in widespread use among children with Type I diabetes mellitus. This development has paralleled the increase in use of home glucose monitoring techniques. As evidence increases indicating that tight metabolic control during childhood may diminish the severity and/or incidence of the long-term complications of diabetes, efforts have intensified recently to establish solid overall diabetes health care in children as early as possible in the course of their disease. These changes have led to the development of a "team approach" to the care of children with Type I diabetes in an effort to treat the whole child in the face of this potentially devastating

chronic disease. Such teams often include a physician, diabetes nurse educator, dietitian, social worker and/or psychologist. The challenge of the health care providers on the pediatric diabetes team is to strike a balance between optimizing the current and long-term physical health of the gowing diabetic child while promoting normal psychosocial and intellectual development.

A major impact on the practice of pediatric endocrinology has also resulted from the recent wide-spread availability of recombinantly derived human growth hormone. While human pituitary-derived growth hormone was first used in GH deficient children over 30 years ago, the limited supply in the past necessitated it be used only in the most severely affected individuals. With the supply barrier now removed, there has been a dramatic increase in interest with regard to defining a broader patient population who may benefit from growth hormone treatment. At the same time, doses and dosing schedules have been greatly refined. As a consequence, pediatric endocrinologists have increasingly found themselves in the role of ethical decision maker when attempting to determine whether growth hormone administration to a given patient is appropriate. The ethical dilemmas created by tremendous quantities of this apparently safe, potent but quite expensive growth promoting hormone are substantial. As a result, debate has been sparked across the country among pediatric endcrinologists and other health care providers confronted with the decision of whom to treat. The potential uses of growth hormone in children not meeting the classical criteria of "growth hormone deficiency" have also found their way into the mass media, further fueling the debate. This discussion promises to only become more complex as physicians, ethicists, medical insurers and representatives of the pharmaceutical industry continue to wrestle with this complex issue.

Perhaps the most exciting recent development in pediatric endocrinology with regard to potential future therapeutic agents has been the tremendously successful use of long-acting GnRH analogs in the treatment of precocious puberty. It has now been 10 years since GnRH analogs were first reported to reversibly suppress the central pubertal axis in children with precocious puberty. During those 10 years, a large clinical experience has been generated so that successful treatment of uncomplicated, idiopathic central precocious puberty has now become routine in the U.S. Though most children to date this period have been treated with daily injections of GnRH analog, the current trend in this country is toward the use of depot preparations requiring only one injection every 3-4 weeks. These analogs have proven quite safe with minimal side effects, while being extremely effective. The success and safety of these agents serves as promise that similar analogs of other hormones may provide new and effective therapy for other disorders of the endocrine system in the not too distant future. ■

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The Changing Face of General Pediatrics

Roland F. Stebbins, M.D., and Robert M. Abrams, M.D. describe the evolution of Holyoke Pediatric Associates, the largest pediatric practice in Western Massachusetts.

Holyoke Pediatric Associates (HPA) was formed in 1970 when the four pediatricians practicing in the greater Holyoke area-Drs. Ralph Levin Epstein, Henry Burhkardt, Roland Stebbins and Robert Abrams—combined their practices.

Holyoke Pediatric Associates is currently the largest pediatric practice in Western Massachusetts serving patients from forty surrounding communities. It consists of a partnership of eight board certified physicians with forty-five clinical and business support staff. The current patient base is 25,000 patients with an average of 2,000 new patients added to the practice each year. There are 52-55,000 patient visits a year with an average range of 170-220 patients seen each day. The practice is open every day of the year (including weekends and holidays) and in the evening on weekdays. In addition to primary care services, HPA provides a fully licensed office medical laboratory, nutritional counseling, in hospital support and education for new mothers and patient education.

Our practice of pediatrics in the 1990's has seen many significant changes from when we first began practicing as pediatricians in our home town, Holyoke, in the early 1960's. These changes in medical practice, like other fields of medicine, have paralleled the changes in our society. Gone are the days of the neighborhood grocery store, the home delivery of milk and the two parent family where the mother remained at home to raise the children.

We now live in a high tech society which has resulted in better overall medical care for our patients. The development of new vaccines eliminated the dread diseases of polio and measles. Highly qualified specialists like neonatologists have saved the lives of hundreds of premature infants who would have been doomed to die in the 60's. In addition sophisticated diagnostic tools such as CAT scans have simplified the diagnosis of complicated medical problems.

With all these wonderful advances we often feel that our personal satisfaction as practitioners has been diminished.

Over the years, the time we have devoted to our practice has decreased. We are now a eight physician group with several pediatric nurse practitioners who help to ease our work load. Instead of being on call every night or every other night we now work one night a week and every third weekend. Our younger colleagues now are able to spend more time with their growing families.

In the sixties there were no emergency room physicians and a great part of our time was consumed covering the emergency rooms at the Providence and Holyoke Hospitals. Also our in-hospital census for sick patients was significantly high, caring for conditions like asthma and gastroenteritis that we now handle as outpatients using such modalities as home updraft machines and oral rehydrating solutions. And the care for our more acutely ill patients has been taken over by the excellent nearby tertiary care center at Bay State Medical Center.

However, with all these wonderful advances we often feel that our personal satisfaction as practitioners has been diminished. When we

began practicing there was no Medicaid and patients who could not afford the $4 visit were given discounts, not charged or seen at the Spring Street clinic at which we volunteered for 2-3 hours a week. There may be an element of nostalgic romanticizing, but we seemed to know our families better and when someone asked for a house call, we would see them after hours and often times would sit around chatting over a cup of coffee.

One of the major areas of our current discontent has been the evolution into a litiginous society. In the 60's the word malpractice was hardly mentioned in our daily conversation and our yearly premiums were in the hundred dollar range.

Despite all the scientific advances and apparent lessened work load, we continue to work at a busy pace. New problems seem to have supplanted the diseases that we have mastered. AIDS, drug addiction, teenage pregnancy and child and sexual abuse now occupy our time and concern. Sophistication about learning problems have made us more involved with school based problems. Office practice management takes up more of our time and our percentage of overhead has doubled from 25% to over 50% in the thirty years that we have been practicing.

As a group we have tried to stay involved with the medical and social needs of our community. We are involved with the Holyoke Health Center where Dr. Bogan spends half his time and the Holyoke High School Clinic of which Paula Condon is the Medical Director. Howard Gold attends the Our Lady of Providence clinic weekly and Roland Stebbins is on the Holyoke Board of Health, while Robert Abrams is the School Physician. David Sigelman volunteers his service at the Holyoke Hospital Developmental Clinic and Jackie Pleet is the medical advisor for high risk mothers at Providence Hospital Prenatal Clinic. Dr. Betsy Brooks spent a half year recently working for the Children's Defense Fund in Washington. Also we are part of the outpatient teaching program for the Tufts Medical School and each week a third year medical student works with us in our office.

Pediatrics is a constantly changing field which has challenged us to meet the needs of the children we care for. We expect the next thirty years to bring further scientific advances and hopefully many of the current social problems that have been confronting us will be solved. ■

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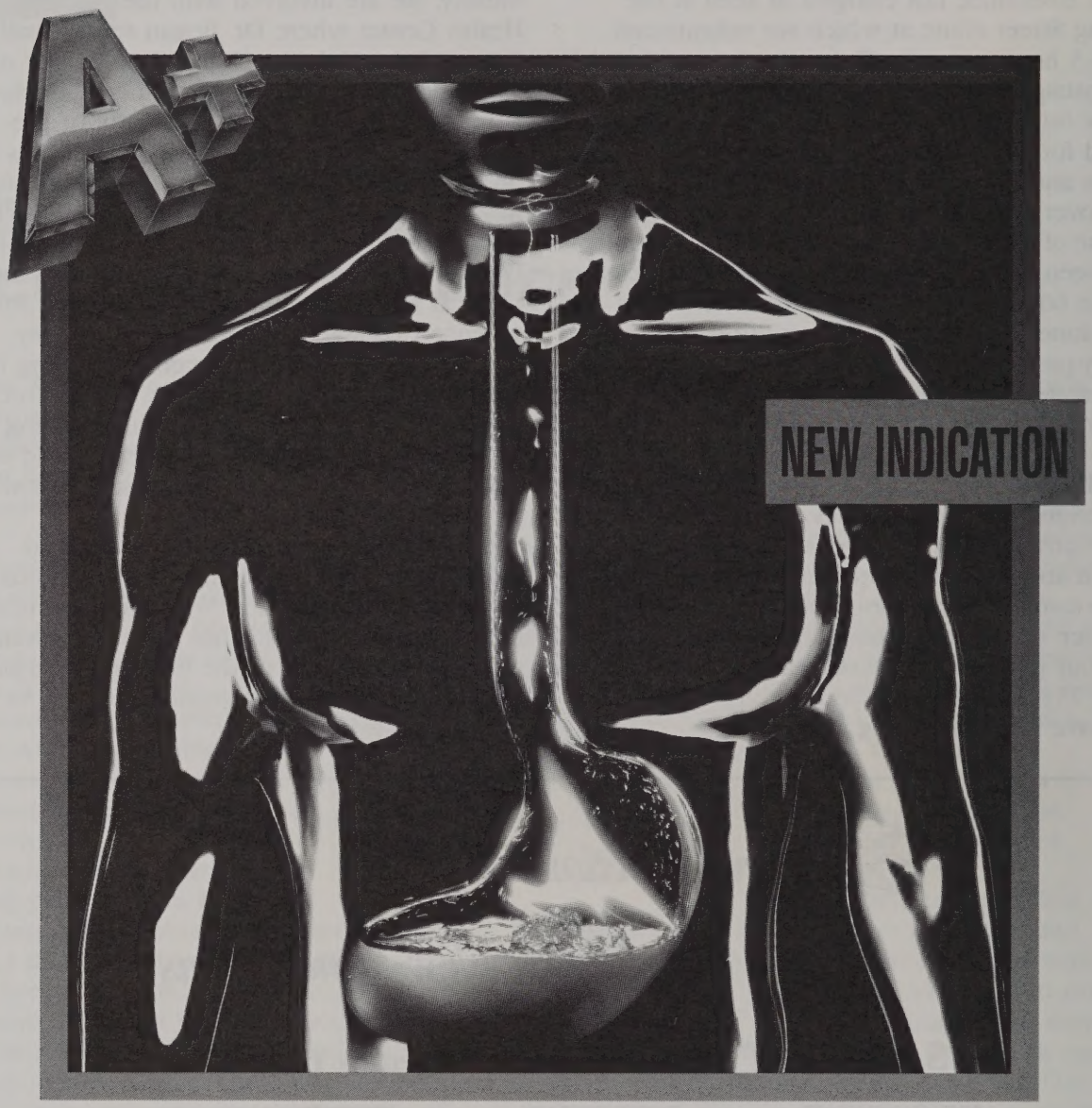

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1. Data on file, Lilly Research Laboratories.

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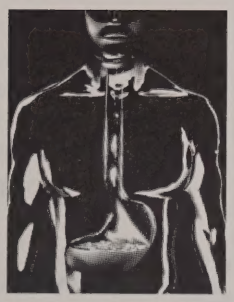

Brief Summary. Consult the package insert for complete prescribing information.

Indications and Usage: 1. *Active duodenal ulcer*—for up to 8 weeks of treatment at a dosage of 300 mg h.s. or 150 mg b.i.d. Most patients heal within 4 weeks.

2. *Maintenance therapy*—for healed duodenal ulcer patients at a dosage of 150 mg h.s. at bedtime. The consequences of therapy with Axid for longer than 1 year are not known.

3. *Gastroesophageal reflux disease (GERD)*—for up to 12 weeks of treatment of endoscopically diagnosed esophagitis, including erosive and ulcerative esophagitis, and associated heartburn at a dosage of 150 mg b.i.d.

Contraindication: Known hypersensitivity to the drug. Because cross sensitivity in this class of compounds has been observed, H_2-receptor antagonists, including Axid, should not be administered to patients with a history of hypersensitivity to other H_2-receptor antagonists.

Precautions: *General*—1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Dosage should be reduced in patients with moderate to severe renal insufficiency.

3. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

Laboratory Tests—False-positive tests for urobilinogen with Multistix® may occur during therapy.

Drug Interactions—No interactions have been observed with theophylline, chlordiazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450 enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increased serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

Carcinogenesis, Mutagenesis, Impairment of Fertility—A 2-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a 2-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups.The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a 2-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy—Teratogenic Effects—Pregnancy Category C—Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in 1 fetus, and at 50 mg/kg, it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in 1 fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers—Studies in lactating women have shown that 0.1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother.

Pediatric Use—Safety and effectiveness in children have not been established.

Use in Elderly Patients—Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Worldwide, controlled clinical trials included over 6,000 patients given nizatidine in studies of varying durations. Placebo-controlled trials in the United States and Canada included over 2,600 patients given nizatidine and over 1,700 given placebo. Among the adverse events in these placebo-controlled trials, only anemia (0.2% vs 0%) and urticaria (0.5% vs 0.1%) were significantly more common in the nizatidine group. Of the adverse events that occurred at a frequency of 1% or more, there was no statistically significant difference between Axid and placebo in the incidence of any of these events (see package insert for complete information).

A variety of less common events were also reported; it was not possible to determine whether these were caused by nizatidine.

Hepatic—Hepatocellular injury (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L) in SGOT or SGPT and, in a single instance, SGPT was >2,000 IU/L. The incidence of elevated liver enzymes overall and elevations of up to 3 times the upper limit of normal, however, did not significantly differ from that in placebo patients. All abnormalities were reversible after discontinuation of Axid. Since market introduction, hepatitis and jaundice have been reported. Rare cases of cholestatic or mixed hepatocellular and cholestatic injury with jaundice have been reported with reversal of the abnormalities after discontinuation of Axid.

Cardiovascular—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in 2 individuals administered Axid and in 3 untreated subjects.

CNS—Rare cases of reversible mental confusion have been reported.

Endocrine—Clinical pharmacology studies and controlled clinical trials showed no evidence of antiandrogenic activity due to nizatidine. Impotence and decreased libido were reported with similar frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported rarely.

Hematologic—Anemia was reported significantly more frequently in nizatidine than in placebo-treated patients. Fatal thrombocytopenia was reported in a patient treated with nizatidine and another H_2-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

Integumental—Urticaria was reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

Hypersensitivity—As with other H_2-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

Other—Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine have been reported.

Overdosage: Overdoses of Axid have been reported rarely. If overdosage occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. The ability of hemodialysis to remove nizatidine from the body has not been conclusively demonstrated; however, due to its large volume of distribution, nizatidine is not expected to be efficiently removed from the body by this method.

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Additional information available to the profession on request.

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"House Calls"

Anthony P. Lovell, M.D., reports on the recent cardiology call-in program.

Fourteen cardiologists recently had the experience of participating in the first of a proposed series of "House Calls" programs sponsored by the public relations committee of the Hampden District Medical Society. The benefits of this program were far reaching. Those of us who participated, albeit somewhat reluctantly at first, eventually did enjoy the excitement of a live TV program in spite of the ceaseless ringing of 14 telephones. We were impressed with the smooth transitions provided by Dave Madsen, along with the superb technical planning by Michael Barnes. We continue to be indebted to Scott Brown and his colleagues from MERCK, who provided the financial support to the Medical Society for this program.

I have personally been astounded by the large number of compliments we have all received from other medical professionals as well as the general public, and, of course, our patients, to whom the show was directed. I was recently informed that we received over 1,100 phone calls to the phone bank during the scheduled three hours. There were an additional 100 or so calls to the station, and to the Medical Society, for additional information and referral.

In summary, this joint effort was far more successful than any of us could have anticipated. I think that the ripple effect in the community continues to be felt. I believe that there is a tremendous need for continued public medical education of this sort for mutual benefit. I can envision future programs which might utilize colorful educational film clips. The areas of Ophthalmology and Gastroenterology immediately come to mind, but I believe that the format of a call-in show is generally applicable to all medical disciplines.

I personally look forward to the future efforts of our colleagues, and promise to watch from the comfort of my living room!■

From the MMS Regional Office

The 1992 legislative package for the Massachusetts Medical Society was filed on November 6, 1991. The thirteen bills approved by the Committee on Legislation for 1992 are as follows:

Neurologically Impaired Infant Compensation:
Would create a non fault based system to provide compensation for neurologically impaired infants.

Tort Reform:
Would implement those tort reform measures not fully achieved by the MMS in 1986 and recommended in national legislation creating incentives for state sponsored tort reform. Examples include: tighter caps on pain and suffering awards, collateral source rules, expert witness standards and periodic payment of damages.

Mandatory Assignment/Licensure:
Would sever the tie between Mandatory Assignment (acceptance of Medicare reimbursement as payment in full) and licensure so that violation of Mandatory Assignment would not mean automatic loss of license; violation of Mandatory Assignment law would carry $1,000 penalty.

HIV Disclosure/Contact Tracing:
Would allow nonconsensual disclosure of HIV status to health-care workers who otherwise would be unknowingly at risk of AIDS infection due to contact with blood; also would require the Department of Public Health to treat HIV infection as other sexually transmitted diseases and undertake contact tracing.

Safe Harbors:
Would amend the "anti-kickback" provisions of the False Health Care Claims Act of 1988 to clarify that the law prohibits only improper or corrupt business practices.

Unit System:
Would repeal the Blue Cross/Blue Shield "unit system" so that physicians are not automatically at risk financially for deficits incurred by Blue Cross or Blue Shield. (Note: this bill was refiled to keep the issue alive in the event that the legislature did not approve the Society's bill at the end of the 1991 session.)

Legalization of Trial Samples:
Would allow physicians to dispense samples of drugs free of charge to patients.

Nonpar:
Would require Blue Shield to provide coverage for the services of physicians who do not sign a participating physician's agreement with Blue Shield.

Lower Blood Alcohol Limits:
Would lower, from .10 to .05, the blood alcohol level needed to prove the crime of driving under the influence.

Insurance Disclosure:
Would require health insurance companies to disclose, in language comprehensible to consumers, all policy provisions which are barriers to access to care or provide incentives to withold care or furnish care in a particular setting.

Utilization Review Regulation:
Would provide comprehensive standards for utilization review programs and establish rights to access to screening criteria and to independent medical review, as well as other important safeguards.

JUA Makeover:
Would extend the life of the JUA while refocusing its board of directors. The current fifteen members would be reduced to eleven, of whom six would represent health care providers chosen by the Commissioner of Insurance from nominees of appropriate professional societies.

Medical Examination For Hairdressers:
Would amend the current laws requiring licensed hairdressers to annually be certified by a physician as being free from infectious disease by inserting the word apparent before the word infectious.

Questions regarding any of these bills may be directed to the MMS Department of Government Relations, or your district representatives on the MMS Committee on Legislation. ■

Kerin L. Milesky
Regional Coordinator
Massachusetts Medical Society

$.....

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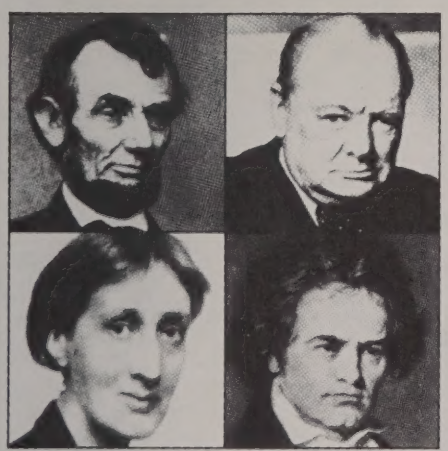

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Tourette Syndrome and Movement Disorder Center

Herbert E. Gilmore, M.D., directs the Center referred to in the title, and described in the following article.

The Tourette Syndrome and Movement Disorder at Baystate Medical Center was established October 1990 for the purpose of evaluating and treating patients with various movement disorders particularly Tourette syndrome and other tic disorders. The Center is located in the Ambulatory Pediatric facilities of Baystate Medical Center at Wesson Memorial Building. The Center was established through a joint effort of the Division of Pediatric Neurology and Psychiatry. It is presently the only Center in Western Massachusetts dealing exclusively with these disorders. Because of the complexity of the medical, psychological and social problems encountered by patients with Tourette syndrome, there is a multidisciplinary approach to the evaluation and treatment of patients with this disorder. To date, 35 patients have been evaluated at the Center for Tourette syndrome or related tic disorders.

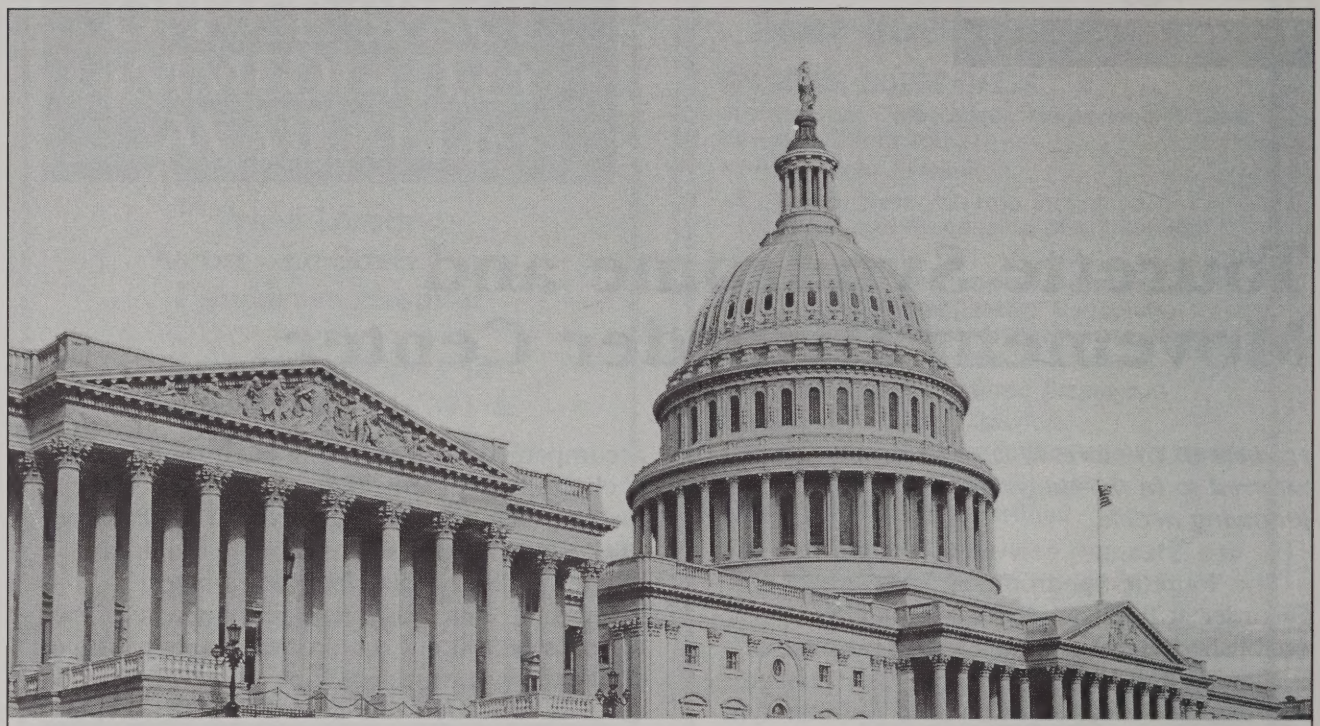
Tourette syndrome was recognized as a neuropsychiatric disorder over 100 years ago and was named for one of the original describers of the disorder, a French neurologist, George Gilles de la Tourette. It was not until the 1960's however, that the disorder was "rediscovered" and not until the 1980's that the disorder has become increasingly recognized in its early stages by the general medical community. More recently, attention has been brought to the syndrome by various talk show programs, television series and press releases. In fact, more patients self-diagnose or self-refer than are referred by physicians!

The diagnosis of Tourette syndrome is a clinical one and it is suspect in any patient who develops a new tic disorder, particularly if accompanied by vocal tics. When the diagnosis is clinically apparent, there is rarely need for further diagnostic testing such as CCT, MRI or EEG. Occasionally, such testing is required when the clinical diagnosis is equivocal.

Recently there has been great interest in the genetics of Tourette syndrome and its possible connection to obsessive/compulsive disorder, other tic disorders and attention deficit/hyperactivity disorder. There is a significant effort being directed towards elucidating the genetic nature of the disorder, which will possibly provide more specific treatment modalities.

The treatment for Tourette syndrome and other movement disorders requires a multidisciplinary approach and the services of pediatric neurologists, child psychiatrists, psychologists and social workers and other therapists and is invaluable. Until recently, the mainstay of treatment of Tourette syndrome has been mainly medical, including various medications such as haloperidol, pimozide, clonidine and others. Unfortunately, many patients complain of adverse side-effects from these medications and seek alternative treatments. More recently psychotherapy, particularly relaxation therapy, has been advocated as useful treatment, or at least adjunct treatment for Tourette syndrome. Many patients with Tourette syndrome either have comorbidity of behavior disorder or develop psycho/social problems secondary to Tourette syndrome.

Any patients suspect of having tics or another movement disorder would be considered appropriate referral to the center. All patients are evaluated initially by a pediatric neurologist who determines the need for further evaluation by child psychiatrist, psychologist, social worker or educational evaluation specialists. To make a referral, or for more information, call Tourette syndrome and Movement Disorder Center, (413) 784-5505. ■



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Most people agree that the U.S. health care system needs significant change. And if a single-payor, national system is adopted, it will change.

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If you find these kinds of changes hard to swallow, maybe you should support a proposal that will build on what's good about America's health care system. And change what's not. A plan like Health Access America.

Developed by the American Medical Association, Health Access America was designed to preserve the integrity of the system while improving programs like Medicare and Medicaid, and requiring employer-sponsored health plans.

So while there's still time, speak for yourself. Join the AMA's call for reform. Call 1-800-AMA-3211 for more information on Health Access America.

Health Access America

The AMA proposal to improve access to affordable, quality health care.

American Medical Association

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New Members Welcome

George Kondylis
558 Newbury Street
Springfield, MA 01104

Born: January 10, 1968
Premed: Boston University 1989
Medical: Bowman Gray School of Medicine 1990-1994
Student

Bret F. Coughlin, M.D.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

Born: August 13, 1959
Premed: U.S. Naval Academy 1977-1979
Holy Cross College, Massachusetts 1979-1981
Medical: UMass Medical School 1981-1985
Internship: Cleveland Clinic, Ohio 1985-1986
Residency: Cleveland Clinic 1986-1989
Fellowship: Brigham and Women's 1989-1990
Specialty: Diagnostic Radiology

Lititia D. Dowe, M.D.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

Born: July 28, 1949
Premed: Southwestern Oklahoma State University 1967-1970
Tulsa University and Tulsa Junior College 1979-1981
Medical: University of Oklahoma College of Medicine 1981-1985
Internship: Tulsa Medical College 1985-1986 (OB/GYN)
Residency: University of Oklahoma 1987-1988 (Preventive Medicine)
University of Hawaii Dept. of Health 1990-1991
Specialty: Public Health/Preventive Medicine

Tammy Van-Truc Pham, M.D.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

Born: June 25, 1964
Premed: University of California, Irvine 1983-1987
Medical: University of California 1987-1991
Internship: Baystate Medical Center 6/91-Present
Specialty: Obstetrics/Gynecology
Resident

Purnima S. Adlakha, M.D.
1221 Main Street, Suite 117
Holyoke, MA 01040

Born: February 1, 1953
Premed: Holkar Science College, India 1970-1971
Medical: M.G.M. Medical College, India 1971-1976
Internship: Sir Ganga Ram Hospital, India 1976-1977
Residency: KJMC, New York 1988-1991
Specialty: Internal Medicine

Patrick T. Tiedeken, M.D.
275 Bicentennial Highway
Springfield, MA 01118

Born: June 18, 1954
Premed: Dickinson College, Pennsylvania 1972-1976
Medical: University of Pennsylvania 1978-1980
Rutgers Medical School 1976-1978
Internship: Presbyterian University of Pennsylvania 1980-1981
Residency: Presbyterian University of Pennsylvania 1983-1986
Pittsburgh Eye/Ear Hospital 1986-1989
Fellowship: Vanderbilt University, Tennessee 1989-1990
Allegheny General Hospital 1990-1991
Specialty: Ophthalmology/Plastic Surgery/Orbital Surgery

Continued on next page

New Members Welcome

Continued from previous page

Jeffrey L. Crosby, M.D.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

Born: October 2, 1953
Premed: Hunter College, New York 1980-1986
Medical: New York Medical College 1987-6/91
Internship: Baystate Medical Center 7/91-Present
Specialty: Internal Medicine
Resident

Alan A. Lareau, M.D.
Baystate Medical Center
140 High Street
Springfield, MA 01199

Born: January 2, 1958
Premed: St. Michael's College, Vermont 1976-1980
Medical: University of Connecticut 1984-1988
Internship: Baystate Medical Center 1988-1989
Residency: Baystate Medical Center 1989-1991
Specialty: Internal Medicine

Arminder Singh, M.D.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

Born: July 4, 1965
Premed: Northwestern University, Illinois 1983-1987
Elmhurst College, Illinois 6/84-7/84
Medical: University of Illinois, Urbana 1987-1988
University of Illinois, Rockford 1988-1991
Internship: Baystate Medical Center 7/91-Present
Specialty: Internal Medicine
Resident

Jeffrey J. Ochs, M.D.
2150 Main Street
Springfield, MA 01104

Born: June 21, 1952
Premed: State University of New York 1968-1972
Medical: State University of New York-Downstate 1972-1976
Internship: St. Vincent Hospital, Massachusetts 1976-1977
Residency: St. Vincent Hospital, Massachusetts 1977-1979
Fellowship: National Cancer Institute, Maryland 1980-1983
Specialty: Internal Medicine/Hematology/Oncology

David D. Agahigian, M.D.
275 Bicentennial Highway
Springfield, MA 01118

Born: December 15, 1955
Premed: University of Connecticut 1972-1976
Medical: University of Connecticut 1981-1985
Internship: Hartford Hospital 1985-1986
Residency: Emory University, Georgia 1986-1989
Fellowship: Rush-Presbyterian, Illinois 1989-1990
Specialty: Ophthalmology/Retina Vitreous

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The Max Millman Symposium 1991

Richard Steingart, M.D. coordinates the annual Max Millman Symposium, which is an endowed lecture held annually for the physicians of the Pioneer Valley.

Dr. Max Millman of Springfield, Massachusetts died at Mercy Hospital on October 31, 1974. He was in good health until the day before his most unexpected death when he was struck with a massive cerebral hemorrhage while playing golf. Dr. Millman was a brilliant teacher and a self made man and the first internist in Springfield to pass the Board of Internal Medicine. For nine years he was the Editor in Chief of the Hampden Hippocrat. During this time it grew from a quarterly publication of four pages to a monthly publication of over forty pages.

The Max Millman Symposium is a yearly symposium set up by the Hematology/Oncology Division of Baystate Medical Center in Dr. Millman's honor. For the past four years the Symposium has had nationally recognized authorities in the field of Hematology discuss topics of multidisciplinary interest.

The subject of the October 25, 1991 Symposium was Transfusion Reactions. The subject was discussed by Dr. Edward Snyder of Yale University Medical Center in New Haven, Connecticut. He discussed the multiple types of transfusion reactions (ABO incompatability). Signs, symptoms and patho physiologic mechanisms of both acute and delayed hemolytic reactions were discussed.

The role of recently introduced white cells filters to decrease febrile transfusion reactions due to white cell antibodies was further discussed. New mechanisms were proposed. Most feel that an antigen-antibody reaction can activate monocytes and macrophages as well as endothelial cells and lymphocytes to produce Interleukin I previously known as "endogeneous pyrogen". This cytokine can cause fever by central activation of a receptor in the brain. It can also cause the liver to produce acute phase reactants. Further it has been recently reported that Interleukin I will bind to a receptor in the above mentioned cells.

The Max Millman Symposium is a high quality lecture which will continue for years to come. ■

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Therapeutic Suggestions

John J. Alifano, Sr. M.D., offers a poetic reflection.

Do not open the door
To strangers that do strand.
Use cautious firm, galore
With those in contraband.

Do not your doctor bore—
That one whose toil is grand;
Praise nurses who in store
Have virtues as before.

Do not avoid the core
Of things under command:
Do aim for a safe shore
With a sagacious stand.

Do not try to restore
A heart that has no "band",
That's broken times of yore,
With efforts lost in sand.

Do not shun a fine lore
And friends who understand.
Pity yourself no more,
Help those who need a hand.

Do not drop from demand,
But learn the proper score:
Do heal yourself that sore...
Your haughtiness ignore. ■

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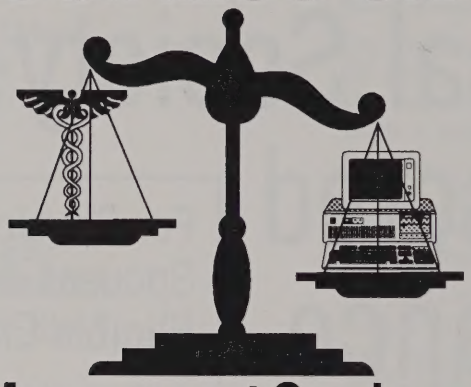

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